A Special Advertising Section Reprinted From the September 15, 2008 Issue of Forbes®

Corporate Healthcare

Improving Healthcare Quality While Reducing Healthcare Costs

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In the United States, healthcare delivery is based on incentives that are backfiring. Big time.

People in need of healthcare are encouraged to visit multiple specialists, undergo multiple tests and procedures and ingest multiple prescription drugs. However, there's little coordination of the care and treatment they receive and little education provided to patients concerning all of the possible actions they should take to maintain and improve their health.

This is because healthcare providers are typically paid for the number of services they provide, even when these services are ineffective, inappropriate or redundant.

How Much Money Are We Wasting?

The results of misplaced healthcare performance incentives are costly:

- Fewer employers can afford to provide healthcare coverage for their employees. In 2000, 64.2% of Americans received employment-based health insurance; by 2006, just 59.7% did, according to the U.S. Census Bureau. Fewer Americans can afford health insurance. In 2006, 46.9 million Americans did not have health insurance — an increase of 22% since 2000.[1]
- Those who can afford health insurance are paying more — much more. Between 2000 and 2007, the annual cost of family health insurance premiums (adjusted for inflation) rose 58% — from $7,643 to $12,106.[2]
- Those who cannot pay for health insurance get sicker and die sooner than those with coverage, according to the Blue Cross Blue Shield Association.[3]

Behind these dramatically negative trends are other figures that point to causes and give a hint of at least some solutions.

Chronic illnesses. The epidemic of chronic illnesses is one of the chief reasons for rising healthcare costs. Chronic illnesses account for 75% of every health dollar spent in America.[3]

Ignoring the need for evidence. Medical professionals often do not know which treatments work best. About 30% of healthcare spending goes to ineffective, redundant and inappropriate care. This translates into $420 billion a year in direct costs (that's 18% of what the U.S. spends on healthcare annually) and up to $210 billion a year in indirect costs.[4]

Among the reasons for this: Only 15% of clinical practices are based on clinical trials, so many treatments are assumed to work when there is in fact no evidence that they do work. In addition, failure to provide treatments that have been proven effective is

To make American healthcare better, everyone must engage: healthcare providers, insurers, employers, consumers and government leaders. And the time to engage is now.

endemic. In one study, just 54% of acute care and 56% of chronic care conformed to medical literature, and generally, adults received about half of clinically recommended care.[3]

Lack of information. Key information and tools are unavailable to healthcare providers and consumers alike. Such lack of transparency is costly: Every year in the U.S., 1.5 million adverse drug reactions occur that could have been prevented with tools like electronic prescribing.[3]

The deadly bottom line. Yawning quality gaps in the U.S. healthcare system cause 35,000 to 75,000 avoidable deaths each year and between $2.7 billion and $3.7 billion in avoidable medical costs.[5] Americans spend $2.3 trillion a year on healthcare and must cope with a system in which there's only about a 50-50 chance of getting the most advisable treatment.[3]

Moving Toward a Solution

The good news is that healthcare providers are now moving away from thinking about patient safety in terms of medical errors to instead thinking about patient safety in terms of "doing no harm." It's an important distinction because it focuses on the patient and the reliability of overall patient care. This shift in focus is creating a new culture of vigilant awareness, understanding and sense of responsibility for patient safety.

All of this is happening as Medicare reimbursement is changing. On October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) will begin implementing value-based purchasing (VBP) — also known as pay for performance (P4P) — in phases over a period of several years. Top performers will receive incentives based on quality measures. Organizations unable to meet specified standards will lose reimbursement.

This matters because the federal government spends some 46% of U.S. healthcare dollars. As baby boomers age and America deals with chronic illnesses and the effects of obesity (which affects 32% of Americans, a statistic that is climbing), healthcare spending is expected to rise to more than 19% of GDP by 2015, up from 16.2% in 2007.[6]

What Will It Take to Meet These Challenges?

Reducing or eliminating disparities in treatment could save Medicare alone up to 30%, while also delivering more efficient care without compromising health outcomes.[4]

But what will it take — not just for those on Medicare, but for all Americans — to enjoy cost-efficient, consistent-quality healthcare? It will take new programs. In particular:

- **P4P programs that reward healthcare providers who efficiently deliver evidence-based care.** Key here is use of quality measures that are clinically important, credible to physicians, transparent to all stakeholders, consistent across health plans and other payers and understandable and useful to consumers in making choices. It's also critical that providers have the information and tools necessary for improving practice outcomes and efficiencies.
- **Incentives for consumers, providers, employers and payers to adopt health information technology.** This includes personal health records and development of an interoperable health record system that enables seamless and secure transmission of health information.
- **Improvements in the transparency of healthcare quality and pricing.** This will give consumers easy access to healthcare information, including cost and price information, and the ability to seek out hospitals and other healthcare providers that have a proven track record of high-quality care.
- **Emphasis on preventive care.** This includes greater integration among medical, behavioral and dental health services to facilitate

total wellness, as well as vigorous promotion of wellness programs and provision of wellness tools, such as health risk assessments, weight management and smoking cessation programs.

New Incentives at Work

Members of the Blue Cross and Blue Shield Association — a federation of 39 Blue Cross and Blue Shield companies that collectively provides healthcare coverage for one in three Americans — are engaged in numerous efforts to improve healthcare quality. Among these efforts are:

Collaboration. By working with other teams, the Pediatric Rapid Response Team at Duke University Health System produced a 65% relative risk reduction in the number of non-pediatric intensive care unit (PICU) cardiac arrests, a 56% reduction in deaths from the non-PICU cardiac arrests and a 25% reduction in non-PICU inpatient deaths. The Duke University Health System participates in Blue Cross and Blue Shield of North Carolina (BCBSNC) networks.

Blue Cross and Blue Shield of Alabama has partnered with Alabama hospitals and Cardinal Health MedMined services to collaborate and act on healthcare-acquired infections, hospital-wide and statewide. The result so far? Hospitals have reduced infection rates by 19% and in some cases by as much as 40% in one year.

Blue Cross Blue Shield of North Dakota (BCBSND) piloted a collaborative diabetes disease-management program. Thanks to the program, BCBSND reports decreases in emergency room visits and inpatient admissions, and it estimates $100,000 to $300,000 in savings from the disease-management program.

Pay for performance. Through the Quality-in-Sight Hospital Incentive Program (Q-HIP), which aligns financial incentives with quality improvements, hospitals participating in Anthem Blue Cross and Blue Shield in Virginia have decreased complication rates in one year by 50% and 29% percent, respectively, for angioplasty and cardiac catheterization.

Information technology. CareFirst BlueCross BlueShield collaborated with DrFirst, a healthcare software company, to equip 275 providers with an e-prescribing tool. Participating providers were given a wireless-enabled PDA loaded with e-prescribing software so they could electronically send prescriptions to their patients' pharmacies. In 2006, participating providers registered a total of 550,000 prescription transactions that triggered 15,000 drug interaction warnings and 7,400 drug allergy warnings. If some or all of these prescription transactions had gone unnoticed, patients' health or lives could have been jeopardized. CareFirst estimates that the warnings to physicians produced $1.6 million in savings.

BlueCross BlueShield of South Carolina (BCBSSC) has implemented an innovative program that streamlines insurance pre-certification processes. Currently, over 46% of all pre-certification requests and inquiries are handled online, greatly reducing the use of long-distance telephone calls. Cumulative costs savings tallied $1.4 million by the end of 2007.

Improvements and cost savings are already adding up, but there's a very long way to go. To make American healthcare better, everyone must engage: healthcare providers, insurers, employers, consumers and government leaders. And the time to engage is now. ■

Web Directory

Blue Cross Blue Shield
www.bcbs.com

Notes:

1 U.S. Census Bureau, August 2007; from http://www.reuters.com/article/pressRelease/idUS15591+29-Jan-2008+PRN20080129

2 *Employer Health Benefits 2007*, Kaiser Family Foundation and Health Research and Educational Trust (http://www.kff.org/insurance/7672/upload/76723.pdf)

3 *The Pathway to Covering America*, 2008, Blue Cross Blue Shield Association (http://www.bcbs.com/issues/uninsured/pathway-to-covering-america/)

4 *Quality: Pay for Performance*, http://www.aetna.com/about/aoti/aetna_perspective/quality_pay_performance.html

5 *To Your Health! Aetna's Proposal for Healthcare System Transformation* (http://www.aetna.com/news/2008/To_Your_Health_Aetna_Proposal_for_Health_Care_System_Transformation062008.pdf)

6 *Medical Cost Reference Guide*, Blue Cross Blue Shield (http://www.bcbs.com/blueresources/mcrg/MCRG.pdf)

The Blue Cross and Blue Shield System strongly believes everyone should have health insurance. Addressing rising costs and extending coverage to everyone must become a national priority. That's why we introduced a comprehensive, five-part proposal called *The Pathway to Covering America*, which builds on the success of today's employer-based system to improve the quality of our healthcare and rein in costs while simultaneously extending coverage to all.

Specifically, we believe successful healthcare reform must:

1) **Encourage** research on what works and put that information quickly into practice
2) **Change** incentives to promote better care
3) **Empower** consumers and providers with information and tools to make informed decisions
4) **Promote** health and wellness
5) **Foster** public and private coverage solutions to address the uninsured

More details on this proposal as well as information on what BCBS companies are doing to expand access and coverage to all Americans and improve the quality and value of our healthcare system are available at:

www.bcbs.com/pathways

BlueCross BlueShield Association
An Association of Independent Blue Cross and Blue Shield Plans